— TO BE COMPLETED BY OCCUPATIONAL HEALTH OR DELEGATE PHYSICIAN —

PHYSICIAN'S WRITTEN OPINION
RESPIRATOR USE CERTIFICATION

PLEASE PRINT LEGIBLY AND COMPLETELY FILL-OUT BELOW	
LICENSED HEALTH CARE PROVIDER (LHCP) NAME	
ADDRESS	
TELEPHONE NUMBER	
EMPLOYEE NAME (PRINT)	
HOME ADDRESS	
TELEPHONE NUMBER ( )	DATE OF EXAM
DEPARTMENT	BUREAU
JOB TITLE	

☐ NO RESPIRATOR USE ALLOWED

☐ THE ABOVE NAMED PERSON IS MEDICALLY QUALIFIED FOR FIT TESTING AND UNLIMITED USE OF RESPIRATORY PROTECTION DEVICES

☐ THE ABOVE NAMED PERSON IS MEDICALLY QUALIFIED FOR FIT TESTING AND LIMITED USE OF RESPIRATORY PROTECTION DEVICES BASED ON THE FOLLOWING RESTRICTIONS:

THE EMPLOYEE QUALIFIES TO USE THE FOLLOWING TYPES OF RESPIRATORS ONLY:	LIMITED TIME	2-4 HOURS	Over 4 HOURS	ESCAPE ONLY
☐ LEVEL 1 FILTERING FACEPIECE (DUST MASK)				
☐ LEVEL 2 POSITIVE AIR PRESSURE RESPIRATOR (PAPR)				
☐ LEVEL 3 AIR PURIFYING RESPIRATOR (CARTRIDGE/CANISTER)				
☐ LEVEL 4 SELF-CONTAINED BREATHING APPARATUS (SCBA)				
☐ LEVEL 5 AIR LINE RESPIRATOR				

☐ THE EMPLOYEE MAY USE THE RESPIRATORS INDICATED ABOVE WITH THE FOLLOWING RESTRICTIONS:

_____

_____

_____

☐ THIS EMPLOYEE MUST HAVE FURTHER MEDICAL EVALUATION PRIOR TO QUALIFYING FOR RESPIRATOR USE.

☐ THIS EMPLOYEE MUST HAVE RECERTIFICATION: ☐ ANNUALLY ☐ BIENNIALLY

☐ THE EMPLOYEE HAS BEEN REFERRED TO A PERSONAL PHYSICIAN FOR FOLLOW-UP MEDICAL EVALUATION

PHYSICAN'S SIGNATURE	DATE

Original maintained with Occupational Health or delegate physician files.

Copies returned to: **MICHAEL ALIO, 333 W. OCEAN BLVD, 10TH FLOOR, LONG BEACH, CA 90802 and to employee.**